

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=63-009791

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

317

Primary Registration District No.

500

Registrar's No.

412

STATE FILE NUMBER

FILED FEB 19 1963

1. PLACE OF DEATH

a. COUNTY

St. Louis

b. CITY (If outside corporate limits, give TOWNSHIP only)
OR
TOWN

Length of stay in 1b
7 Years

c. FULL NAME OF (If NOT in hospital, give location)
HOSPITAL OR
INSTITUTION

Hubbattt Nursing Home

Inside Limits
Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE Missouri b. COUNTY

c. CITY
OR
TOWN St. Louis

Inside Limits
Yes ☒ No ☐

d. STREET
ADDRESS (If outside, give location)
5367 Queens

Reside on Farm:
Yes ☐ No ☒

3. NAME OF DECEASED
(Type or print)

First

Middle

Last

JOSEPHINE

GRADY

4. DATE
OF
DEATH

Month
February

Day
4

Year
1963

5. SEX

Female

6. COLOR OR RACE

White

7. Married ☐ Never Married ☐
Widowed ☒ Divorced ☐

8. DATE OF BIRTH

9/28/1890

9. AGE (last birthday)

72

IF UNDER 1 YEAR

Months Days Hours Min.

IF UNDER 24 HR

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired Sales Lady

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and state or country)

St. Louis, Missouri

12. CITIZEN OF WHAT COUNTRY

U.S.A.

13a. FATHER'S NAME

Patrick Geary

13b. MOTHER'S MAIDEN NAME

Mary Reardon

14. NAME OF HUSBAND OR WIFE

James Grady (Dec.)

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes, give war or dates)

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

Mrs. Wm. Geary, 5367 Queens Ave.

18. CAUSE OF DEATH (Enter only one cause)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Chr. Myocarditis

INTERVAL BETWEEN
ONSET AND DEATH

4 yrs

Conditions, if any,
which gave rise to
above cause (a),
stating the under-
lying cause last.

DUE TO (b)

Arterio-sclerosis

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

Cerebral thrombosis - 5 yrs

PART III. If deceased was female was there a pregnancy in last 90 days.

☐ Yes ☒ No ☐ Unknown

19. WAS AUTOPSY
PERFORMED?
YES ☐ NO ☒

20a. ACCIDENT SUICIDE HOMICIDE

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF
INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED
WHILE AT WORK ☐
NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home,
farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from May 5, 1958, to Feb. 4, 1963 and last saw her alive on Feb. 4, 1963
Death occurred at 6:15 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

(Degree or title)

22b. ADDRESS

9385 Page Blvd
St. Louis 14, Mo

22c. DATE SIGNED

Feb. 5, 1963

23a. BURIAL, CREMATION,
REMOVAL (Specify)

23b. DATE

2/6/63

23c. NAME OF CEMETERY OR CREMATORY

Calvary Cemetery

23d. LOCATION (City, town, or county)

St. Louis

Missouri

24. FUNERAL DIRECTOR

ADDRESS

BUCHHOLZ MORTUARY, INC. 5967 W. Florissant

25. DATE RECD. BY LOCAL REG.

2-5-63

26. REGISTRAR'S SIGNATURE

John B. Murphy M.D.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Walter J. Buchholz

Licensed Embalmer No. 4551

P. O. Address St Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.